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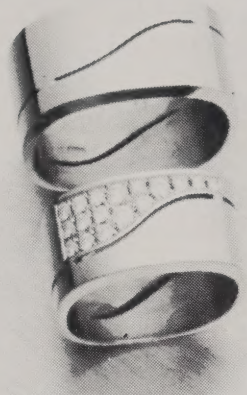

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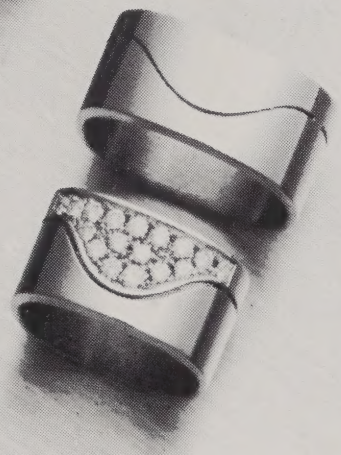

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THE HAMPDEN HIPPOCRAT

VOLUME XXXXII NO. 9
APRIL — MAY 1986

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HAMPDEN DISTRICT MEDICAL SOCIETY 1986-1987 SEASON

Annual Meeting

PLACE:	Carriage House Old Storrowtown Tavern West Springfield, MA
DATE:	Monday, April 21, 1986
BUSINESS MEETING:	6:00 p.m.
SOCIAL HOUR:	7:00 p.m.
DINNER:	7:30 p.m.
SPEAKER:	Eric N. Berkowitz, Ph.D., Chairman Department of Marketing at University of Massachusetts
SUBJECT:	"The Changing Environment of Medical Practice; A Marketing Perspective.

NOTE: If you must cancel your dinner reservation, call the office before noon on April 21st. If the cancellation is not made, you will be BILLED for your dinner.

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Society is asking our members for voluntary payment of $15.00 for their own dinners to help us defray costs.

THE HAMPDEN HIPPOCRAT

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APRIL — MAY 1986

VOLUME XXXXII NO. 9

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D., and William A.R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT is published bi monthly.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
All communications should be addressed to Carol L. Nystrom, Hampden District Medical Society, 1414 State St., Springfield, Mass. 01109: Telephone: 736-0661.
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HDMS President's Message

Augusto G. Asinas, M.D., President

The issue of the medical malpractice is still very much in the forefront now adays. Recently Senator Linda Melconian has announced to the physicians at the legislative breakfast meeting with the area legislators that the medical malpractice reform bill is just about to be reported out of the combined legislative committee of which she chairs. Following this will be another hearing for the bill at the state house prior to its introduction to the legislature for a final vote. She has indicated some aspect of the proposal that we will not be happy with. On the subject of a cap on the malpractice award for pain and suffering her committee had a tie vote, therefore did not favor or propose any cap.

I personally think this is a very important factor to consider in the ever increasing premium for the insurance of malpractice and therefore will greatly impact on the ability of the physician to deliver quality health care. This cap will also help very much the JUA insurance companies to actuarily determine or project future insurance premiums. The membership should be keenly aware of the future impact of the up comming legislature bill to reform the medical malpractice in the state of Massachusetts. Much is at stake for all of us. I would like to ask all of you again to contact your legislators and express your concern regarding this bill.

The workmens compensation reform act of 1985 has been made into law. You all received a copy of the report from our president of the Massachusetts Medical Society. Dr. Barbara Rockett has indicated that the act will bring some relief for services rendered. However it will increase the cost of administration. She will keep us informed as further implementations of the statue is being made. I personally do not feel there will be much relief on the part of the physician who is burdened by much paper work in rendering services to the injured worker.

By now all of you are aware of the multiple alternative delivery of health care being offered in our region. I appeal to your wisdom to make choices as to what is best for your patients and suitable to your medical practice. All of these have slowly eroded our ability to practice medicine privately. My only hope is that the trend will reverse itself and once again we can all be happy practicing medicine the way we were trained to do so.

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Medicine Through The Years

by Margaret, Stoler, Springfield Academy of Medicine

In conjunction with the 1986 Physician Portrait Fund Drive, a series of articles will appear in the Hippocrat giving an overall view of the development of medicine from the colonial period to the present.

1886-1936

Following the Civil War, the nation experienced strong economic growth in industry as well as agriculture. Major emphasis was on production rather than people. Much of the Federal Funds for research went to the Dept. of Agriculture. Farm animals were valuable; human life was cheap. The number of physicians far exceeded the demand. Those practicing in cities usually taught at one of the numerous medical schools while their counterparts in smaller communities engaged in local politics and served "as 'father confessors' blaming everything from loss of hearing to irregular heart beat on masterbation". All patients expected to be treated at home. To open an office suggested charlatanism, holding attraction only to the very poor. Little concern was held for what was beginning to be accomplished in laboratories.

American medicine lagged far behind that of Western Europe, particularly Austria and Germany. In 1892 the U.S. Bureau of Education reported the "productive funds" for medical schools was a little over $600,000 whereas endowments for schools of theology amounted to well over seventeen million. The J.A.M.A. in 1894 published a series of stinging articles directed at the fradulent medical institutions and the degraded state of medical education in the U.S. Dr. William Osler stated:

> "It makes one's blood boil to think that there are sent out year by year scores of men called doctors who have never attended a case of labor...who may never have seen the inside of a hospital and who would not know Scarpa's Space from sole of the foot..."

Increased agitation by the A.M.A. resulted in closing of seventy six medical schools.

John Hopkins led the way in changing medical education from the lecture hall to the laboratory, clinic and bedside teaching. He, himself, had a limited education but managed to accumulate substantial wealth in business. His neighbor, Dr. Patrick Macauly, strongly supported hospital experience in clinical instruction in his address to the Medical and Chirurgical Faculty of Maryland in 1823. Many of Macauly's books were found in the Hopkins library after his death.

Upon his death, Hopkins left nearly seven million dollars to establish a University in 1876, to be followed by a modern hospital in 1889. He also stipulated that a baccalaureate degree be required for medical school; that both men and women be accepted; that two years be spent in the classroom and two years caring for the sick in the proposed hospital; and that a graded system of postgraduate education for interns and residents be established. These were the very words of what is now known as CME credits.

An organized campaign to endow the medical school began in 1889. Elizabeth Garrett, daughter of a trustee, donated over a quarter of a million dollars, with the provision that women receive an MD degree equal to those conferred on the men. Dr. John Councilman, a highly respected member of the faculty, resigned under protest and was immediately hired by Harvard. William Osler wryly retorted: "Johns Hopkins took the money, Harvard took the man." Over the ensueing years such names as Harvey Cushing, William Osler, William Halsted and Henry Welch appeared on the Hopkins roster.

With greater emphasis being placed on clinical study, came the need for more hospitals. The bed capacity at Presbyterian Hospital in New York in 1889 was 130. By 1929 it contained 612. Another aspect which increased the amount of surgery performed was Lister's antisepsis. Though his theory was originally rejected, one of London's leading surgeons frequently regaled his assistants with "...shut the door quickly in case one of Lister's microbes comes in", it was soon recognized as one of the greatest achievements in medicine. Many years after Lister addressed King's College on his theory in 1877, one of the students wrote:

> "I sadly confess that we students were bored and we showed it...we shuffled our feet and reminded the lecturer (Lister) that his hour was up and it was time for tea."

Operations such as appendectomy and gall bladder surgery were begun in the late 19th century but it was several decades before early diagnosis was developed. As late as 1936 as many as 16,480 deaths were attributed to appendicitis and its complications. Other surgical procedures that were developed in the late 1800's were gall bladder stones, inquinal hernia and cholecystotomy. When William Halsted's mother was diagnosed as having an infected gall bladder none of the local physicians in upstate New York felt competent enough to operate so Halsted, himself, successfully completed the surgery.

William Halsted was trained in Austria where he, at first, ridiculed the large number of clamps used in surgical procedures until, as he wrote his mother "...it dawned on us that we in America were novices in the act as well as the science of surgery". Upon his return he designed what is known today as the Halsted Clamp.

As a young surgeon in New York, Halsted experimented using cocaine as a regional nerve block anesthetic. Unfortunately, he became addicted and was institutionalized for an extended period of time. Upon his release and fully aware of

Continued on next page

Medicine Through The Years

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his past, William Welch asked him to head the Dept. of Surgery at Johns Hopkins. Having never really overcome his addiction, he confided in 1892 to Osler that he had lowered his daily requirement of morphine which he had substituted for cocaine, to less than three grains a day. In 1898, he lowered it to one and a half grains daily.

Though viewed as stern and rigid, Halsted was not above a practical joke from time to time. At dinner one evening he complained to his close friend, William Welch "...I have a pain. Its an aneurism. Put your hand under my vest and see if your don't think I'm right." When Welsh felt acute pulsations, he became alarmed, only to find that Halsted had attached a small rubber bag which had a tube with a small rubber bulb at the end and which Halsted placed in his pocket. As Welch palpated the aneurism, Halsted squeezed the bulb causing the bag to burst in Welch's hand.

Halsted contributed much to the practice of surgery. He discovered that rough handling of tissue delayed healing and could cause infection, that closing surgical incisions layer by layer reduced tension which interfered with the blood supply causing delay in the healing process. When his head nurse (the future Mrs. Halsted) complained her hands were sensitive to bi-chloride of mercury, he devised gloves made of rubber for her to wear. His chief resident, Dr. Joseph Bloodgood, found that the twenty operations he did prior to wearing gloves, resulted in four developing infections, but in his next 100 operations wearing gloves, no infections occured. It is not difficult to understand why William Halsted is considered the "Father of Surgery".

This period also witnessed another major advancement in medicine. In 1895, Prof. William C. Roentgen was experimenting with a Crookes tube, a bulblike glass structure from which air has been exhausted and into which positive and negative electrodes have been sealed. He covered the tube with heavy black cardboard and laid it down near a piece of paper coated with barium platinocynide. After repeating the procedures several times, he concluded that rays of some sort were *eminating* from the tube, passing through the covering and having a luminescent effect on the paper. Next he discovered that a photographic plate was affected by the rays just as it was to ordinary light. The first indication Roentgen had as to what this might mean in medicine was when he viewed the bones in his wife's hand using this procedure.

News of Roentgen's discovery spread like wildfire. Less than two months later, Dr. James Burry, a Chicago surgeon, used a Crookes tube to locate a small buck shot in a patient's hand. In 1896, the remarkable Thomas Edison not only developed a fluorescent screen but made it practical enough to be purchased by physicians. The recognition of the dangers of radiation exposure came early when one of Edison's laboratory workers was forced to have both hands cut off due to over-exposure changes.

In 1897, Dr. Frances Williams of Boston, considered the first American radiologist, demonstrated enlargement of the heart with x-rays as well as the ability to detect pulmonary TB far earlier than any other method.

That same year Dr. Walter Cannon, on the faculty at Harvard, overheard two women discussing the horrors of that new machine which "let the doctor see right through you and see all that was going on." This set Cannon to experimenting with a dog. First feeding it buttons and watching them pass through the stomach, he then fed it salts of metal which passed from the esophagus to the rectum. Cannon continued his research at Harvard and in later life, suffered from x-ray dermatitis.

While interning at Mass. General Hospital in 1989, Harvey Cushing purchased a Crookes tube in hopes the hospital would be delighted and reimburse him. They were not impressed so when he left to serve as resident at Johns Hopkins, he took the tube with him. In 1912 he wrote to his mother:

"It is great sport (x-ray)-very useful in the Out-Patient
to locate needles etc. We could look through the chest
readily this morning, count the ribs-see the heart beat,
the edge of the liver. It is positively uncanny."

In 1916 Dr. Walter Dandy, working under Halsted, observed air bubbles on x-ray during intestinal surgery. He began experimenting on dogs, injecting air into ventricles of the brain. By 1918, he succeded in localizing brain tumors in three of his eight patients. Dandy also developed contrast for x-raying kidneys and bladder. Dr. Samuel Crowe who worked closely with both Cushing and Dandy concluded that "Walter Dandy, to an even greater extent than Cushing, had the kind of creative imagination, intuition and persistence which we are accustomed to regard as the hightest form of genius."

The greatest challenge in the proper use of x-ray was devising the right contrast materials. The problem of finding the right contrast material plagued Dr. Evarts Graham at Washington University in St. Louis in 1923. He had experimented with various combinations unsuccessfully. After further research in materials used to x-ray the gall bladder and bile ducts, he came upon a combination of Phenolphtalein and iodine. This, too, was not successful until the animal caretaker did not show up to feed the animals the night before. The following morning, the dog's gall bladder was beautifully outlined due to a totally empty digestive system.

Though major advances were being made in the fields of surgery and radiology, there were few if no advances in the study of disease until the government, as well as a few of the very wealthy citizens of the U.S., began to focus their attention and funds to the problems of public health.

In 1891 Osler published his book *The Principles and Practice of Medicine* which caught the interest of the Rev. F.T. Gates, a close friend and advisor to John D. Rockefeller, who provided funds to establish the first medical research institute in the U.S. in 1901. Within a few years similar centers were established throughout the country by families such as the McCormicks, the Philips, and the Carnegies.

In 1830, Lemuel Shattuck wrote: "The dreadful disease (tuberculosis) is a constant visitor to all parts of our Commonwealth but creates little alarm because it is so constantly present whereas the occasional visit of cholera or other epidemic disease creates alarm and, therefore, precautionary measures are taken." In 1894 one fourth of the population died from the disease. By 1940 only 400 in 100,000 citizens developed TB. Factors contributing to the decline include virtual elimination of the bovine type of infection by pasteuriza-

tion of milk, x-ray surveys and insitutional care in private sanatoria. In 1940, Parke Davis & Company produced a new compound, Promin, which showed some positive signs as being a solution. It was not until Streptomycin was tested on four guinea pigs at the Mayo Clinic laboratory that the beginnings of a cure was recognized.

Though the last major epidemic of yellow fever occured in 1878, by 1900, the disease still posed a problem when the U.S. acquired territory in the West Indies. The Army set up a commission to study the disease. The Chairman of the Commission was Dr. Walter Reed and the Commission discovered that not only was the virus carried by mosquitos but that it was also invisible under the microscope. The work of the Yellow Fever Commission was one of the great achievements in medicine. A vigorous campaign to eradiacate the mosquito in Havanna was set up and was so successful that for the first time in a century, not one case of yellow fever was reported in the city.

The Spanish and American War also revealed the enormity of the disease typhoid fever. Of the 107,973 soldiers encamped within the U.S. border, 20,738 contracted the disease. A Commission was established, headed by Dr. Walter Reed. The findings of the Commission were that the disease was spread by human contact and by unsanitary conditions. Consequently, new latrines were constructed, drinking water protected from contamination by sewage and mess halls screened. In 1909 the entire U.S. Army was vaccinated against typhoid fever. In that year there were 173 cases, whereas in 1912 the number was reduced to 12.

With the outbreak of WW I, major epidemics of communicable diseases broke out; measles, meningitis, mumps and influenza. Over one half of the deaths from disease were attributed to influenza. Base hospitals were staffed by medical school and civilian hospital staffs such as Presbyterian Hospital in New York, Harvard Medical School, as well as Yale and Northwestern. The Johns Hopkins group received orders to board the troop ship and set up a base Hospital in Vosges, France which was staffed by 7 physicians, 15 nurses, and 148 enlisted men, 32 of whom were second year medical students. Through the coordination and cooperation of the American Medical Association and the American College of Surgeons, medicine did a much better job during WW I than during any other previous war.

One aspect resulting from WW I was increased government involvement in the field of medicine through medical care during the war and for veterans after the war. Prior to the war, in 1912, the U.S. Public Health Service was established "to study and investigate the diseases of man and propagation of spread thereof, including sanitation and sewage...". At the onset of the war, the service was greatly expanded. Over two million dollars was appropriated for the study of venereal diseases alone. By 1918, monies were expanded to $3,000,000 and in 1918 Congress allotted $50,000,000 to be divided among the states to set up Venereal Diseases programs available to the public at large.

As early as 1887 William Welch pressed for state public health organizations to be established and frequently addressed the subject openly. In a speech delivered to the Maryland State Assembly he stated:

> "It is self evident that wretched food, filthy surroundings, close and impure air and overcrowding must affect not only the health but also the habits and morals of those subjected to such an environment?"

In 1888 the first government sponsored hygenic laboratory was established on Staten Island as the U.S. Marine Corp. Hospital Laboratory. It was enlarged in 1902 and in 1930 moved to Washington D.C. as the National Institute of Health. Also in 1930 Pres. Herbert Hoover led the nation in honoring Dr. William Welch on his eightieth birthday. Welch again spoke out on the need for a government agency on health care:

> "The creation of a national government agency would provide the best means to coordinate the various municipal and state bureaus. Since poverty represents an acute national issue the federal government has a constitutional obligation to participate in the work."

Though medical research was making great strides, the medical care for most of the people was not. Frequently patients would forego the drug prescribed due to the cost or the orthopedic patient would starve in order to afford the prescribed brace. In 1932 two government sponsored studies were published, The Report of the Committee on Medical Education and the Committee on Costs of Medical Care. Three recommendations were presented:

1. Greater development of group practice centered around hospitals.
2. The cost of medical care can be covered by insurance or taxation.
3. Each state study, evaluate and coordinate health services.

The medical community responded with outrage to the report. The J.A.M.A. called the recommendations a step towards communisim and "incitement towards

Continued on next page

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Medicine Through The Years

Continued from previous page

revolution.''A National Health Survey was taken in 1935-36 which canvassed 800,000 families. They found that the quality and amount of medical care was directly related to the family income. Those in rural or poor urban communitites had the most inadequate medical care. In 1937, the government published ''American Medicine: Expert Testimony Out of Court'' which dealt with the shortcomings and inadequacies of medicine in America. A group of New York doctors countered with a publication on ''Principles and Proposals on Medical Care'' claiming the population as a whole should be concerned; that voluntary agencies on local, state and federal levels be funded to cover medical education, research, and hospital care for the indigent and to cover preventative measures. The A.M.A. accused the signers as traitors to fellow physicians. As a whole, the physicians were fairly divided on the issue which made the public aware of the split within the medical community.

In 1938 Pres. Roosevelt convened the National Health Conference which revealed that the National Health Program needed to achieve more equitable distribution of high quality medical care. In 1939 Senator Robert Wagner presented the Wagner Bill. The bill called for medical provisions be incorporated into the Social Security System. The A.M.A. countered with the argument that the bill placed greater stress on the *''extravagently* high cost'' of the proposal when there really was no need at the time. The Wagner Bill was defeated.

Again in 1943 Wagner along with Sens. Murray and Dingell proposed an extention to the Social Security System to compulsory medical and hospital insurance including everything except drugs and dentistry. Again the A.M.A. mounted a campaign and the bill was defeated. In 1944, the A.M.A. opened an office in Washington D.C. anticipating what might become a ''100 Years War'' with the federal government.

Now, fifty years later, the battle is still going on. Medicine has traveled, a very long, hard, road. As a science, it has reached far beyond the highest expectations but its struggle to maintain independence poses the greatest challenge in the coming years. Hopefully, this can be accomplished so that medicine's great accomplishments of the past may be continued into the future.

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The Greater Good

"The Greatest happiness of the greatest number is the foundation of morals and legislation"
-Jeremy Bentham

The problem with aphorisms is that there is always an opposing view. We are aware of the conflict between "Thou shalt not steal" and "The Lord helps those who help themselves." Bentham's concept is a common yardstick for altruism and service. But as practicing physicians, we have been taught to cherish each individual patient. We speak reverently about the patient-physician relationship. Is it possible that we have overlooked a greater good? Is the relationship between many physicians and many patients a higher calling?

We now hear frequently that physicians are doing too much for their individual patients. This is usually said by non-patients, i.e., persons who are not sick. They purport that small-area geographic variations indicate unnecessary care, that more surgeons mean more surgery, and that too much money is spent on health care in the last six months of life. Third-party payors have decided to spend less for health care and are devising ways to popularize their intent. The patient-physician relationship is more and more encumbered with restrictions placed by the well on the care of the sick. We are rapidly developing a system of rationing medical care.

Physicians are familiar with the techniques of appropriate utilization of scarce medical resources. It is called triage, and it was developed for use when there are more casualties than can be cared for ideally in the time available. I think that all physicians today find that time is our most precious resource. We are exhorted to spend more time with our patients, more time with our families and more time on our education (to say nothing about more time on committees). We all need to practice triage.

In order to make our patient-physician contacts more effective, we need to consider the environment in which these contacts occur. Instead of merely complying with increasing regulations, we need to spend more time with the regulators. This includes insurance carriers and business groups, but in the present crisis, this means primarily legislators.

Meeting and writing legislators requires the same communication skills and the same patient advocacy that we use every day. We must always try to understand and respect the other person's point of view. Taxpayers have a legitimate interest in the cost of health care, just as they have an interest in motorcycle safety and the use of seat belts. We must always remember (and remind others) that the patient comes first in the patient-physician relationship. Perhaps our patients really do want outcome liability insurance protection. If so, it should be made available to them. But it should be administered efficiently, its cost should be known in advance, and it should not be called malpractice.

We must not get so busy seeing patients that we lose our opportunity to help them. A good thing which prevents us from enjoying a greater good is, in truth, an evil (Spinoza). Good triage may mean that we stop seeing some patients in order to be able to give effective care. It may mean shortening office hours in order to meet with legislators. It may mean refusing to render some types of care that have been made too inefficient by bad regulations. It may mean moving to a more effective practice location or even stopping practice entirely.

Undoubtedly, physicians would be far more effective if we would act collectively, but this is not our style. We can, however, maintain our individual responsibility for our patient's collective welfare. We must remain morally committed to our patients' collective welfare. We must remain morally committed to our patients' greater needs and advocate legislation on their behalf.

Garry deN Hough, III, M.D.

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Hampden District Medical Society Committee Reports

Executive Committee

The Executive Committee met monthly except in July and August with all meetings presided over by President Augusto Asinas and agendas organized by President Asinas and Mrs. Carol Nystrom, Executive Secretary. Mrs. Virginia Walthall, HDMS Auxiliary President, represented the Auxiliary at the meetings. Mrs. Nystrom presented monthly membership handout reports.

Dr. J.J. Siragusa, Vice President of MMS, gave periodic reports from MMS Executive Board and Dr. Garry Hough, alternate councilor to the AMA gave written reports from the AMA Council Meetings. In April Dr. Smith reported a Medicaid Referral Service was in operation.

Dr. Terry O'Neill, Legislative Chairman, did a taped interview on Channel 40 regarding medical malpractice. Drs. O'Neill, Smith and Slachta organized doctor's stand at malpractice hearing with Sen. Melconian on October 3; Drs. Smith and Slachta made presentations with great support from doctors and auxiliary members attending.

A $50.00 assessment for malpractice to defray costs of TV commercials and TV spots netted $4,000.00 by January. A mini-documentary on malpractice ran on Channel 22 in February with Drs. Bye, Siragusa, Stoddard and Verrilli being interviewed.

In April, 1985, Dr. Hough resigned as Executive Councilor and Dr. Philip Stoddard was elected to replace him. Dr. Terry Ryan was elected alternate Councillor.

During the year guest presentations to the Committee were heard from (1) Donald MacMeekin explaining an excess Malpractice program which later was not felt applicable to the HDMS needs; (2) Dr. John Zadworny discussing the new physician's union in Mass.; (3) Maureen Skipper describing the many facets of the VNA in Springfield followed with a questionnaire given out to the Committee to determine better the VNA expectations by the doctors; (4) Mr. Kaplan outlining Cigna Health Plan, and IPA, to be begun in the area this year.

There were many items on the agendas some of which were (1) acceptance of a revised Personnel Policies Manual; (2) Backing local computer Show; (3)Purchase of a new computer by Dr. Pelletier and his instructions to office personnel; (4) Co-sponsoring Cocktail-Dance with the auxiliary in November; (5) Requesting MMS to give financial support to Westfield for educating public on Fluoridation, which was acted upon favorably by MMS. (6) Funding campaign to inform public of Malpractice Issues relative to each community with testimonies of Drs. Glackin, Herr & Hough presented at October 3rd hearing, being used. (7) Meeting with and appointing John Palumbo, CPA as auditor. (8) Hearing Dr. Fitzpatrick announce drive for contributions for Physician Portrait for Academy of Medicine which subsequently was subscribed and artist commissioned.

Dr. Asinas at Dr. Ross' suggestion for the need appointed her to Chair an Ad Hoc Committee on Women in Medicine to have liaison with MMS similar committee. Also a Hospital Medical Staff Section ad hoc committee to liaison with MMS committee was approved and will be comprised of a medical staff representative from each area hospital. Dr. Tauber will serve on advisory Board of Dept. of Welfare. Residents serving on committees will be voting members. All committees functioned well during the year.

Respectfull submitted,
William W. Walthall, Jr., M.D.
Secretary

Legislative Report

The 1985 Legislative year could be summed up very simply by stating, "Lots of Work - little result."

The biggest issue facing the medical society this year was obviously the medical malpractice crisis. When plans were made in the Fall of 1984 to file tort reform bills, only in our most optimistic mood could we believe that they would initially pass a legislature that is lawyer dominated.

However, great steps forward were made; to the point that

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the governor appreciated some reforms must be made. In an attempt to please everyone he filed legislation that pleased no one and it was not passed. Despite that, enough pressure has been put on the legislature and the governor by all segments of their constituencies, including various actions by groups of doctors, that we can expect some reasonable solutions in this legislative session.

Of the ten tort reform bills that were filed by MMS last year, five were referred to a Study Order. This is a polite way of essentially killing the bill. The bills that were sent to study through S.2293 were:

1. An Act to define the qualifications of an expert witness.
2. An Act to allow for structured settlements.
3. An Act to place contingency fees under a sliding scale which would give a greater portion of damages to the patient while still providing the attorney an adequate fee.
4. An Act to place a cap of $250,000 on non-economic damages.
5. An Act to modify the statute of limitations involving health care providers.

The bill to require dedicated funds to the board of registration received an "ought not to pass" from the Health Care Committee. The legislators complain that medicine doesn't discipline itself, but then denies it the money whereby it can control the activities of physicians.

An Act requiring reporting of medical malpractice claims died on the Senate Ways & Means Committee, and an Act to grant immunity in peer review activities died on the House calendar.

An Act to modify the collateral source rule was originally reported in the Study Order, but was then referred to Committee on Steering & Policy where it was reported "ought not to pass".

An Act to increase the medical tribunal received a recommendation of "ought to pass" from the Committee on the Judiciary, but then died in the Senate Third Reading.

All in all the efforts of the Mass. Medical Society in getting their legislative packages through would seem to have been in vain; in reality, they have not been. We received the attention we need to move forward on tort reform.

The bills which were filed last year will be refiled. Also, bills which would effectively cap malpractice premiums or would require third party payors to participate are also being filed.

Hopefully 1986 will have better results than did 1985. Rest assured that your elected officials are working very hard in the best interests of medicine. Most of all remember - they need your help.

Terrence M. O'Neill, M.D.
Chairman

Publications Committee Report

This issue of the *Hippocrat* marks the completion of the first full year of the new format we promised in last year's report. Even with the additional expense of adapting to this, we have managed to stay within our budget.

The committee has attempted to "catch the spirit" of Hampden County, Massachusetts and even U.S. Medicine in its articles and features, and we continue to request submission of the same from all of you.

Once again, we thank the many businesses and individuals who support us with their ads; without them, we couldn't produce much more than a mimeographed bulletin.

Thanks also go to Sandy Burkin for managing the ads and to "the two Carols" for all their cheerful help.

William J. Baker, MD
Nicholas P. W. Coe, MD
Terry D. Ryan, MD

Public Relations Committee

As chairman of the Public Relations Committee of the HDMS, my main thrust this past year has been a reactive rather than a proactive stance. Hardly a week has gone by that requests of newspaper, T.V., or radio reporters have not been fielded by your chairman or steered to a cooperative and knowledgeable member. Issues ranging from infant mortality, Medicaid access, malpractice, legislative limitations on licensure, policing of physicians, Blue Shield, the PRO, PSAM and even whether a physician should attend his patient's funeral are just a few of the issues which have been responded to. The list of issues to which one must respond in this era seems endless.

In addition, the Springfield Newspapers have run articles exploring the malpractice problem and WWLP has run similar series on their evening news with cooperation of our members. The Sunday morning program "Argument" on Channel 22 has run half hour segments on obstetrical care, the dangers of boxing, and the malpractice problem with the gracious help of your fellow physicians.

In all, I think we have obtained better press relations and a slightly better understanding by the public of some of the problems the Massachusetts physicians face. I have asked Dr. Slachta to find a chairman who has the imagination and energy to give you a more proactive and promotional type of Public Relations Committee for next year.

Thank you for the honor of representing our problems to the public for you these past two years.

Terry D. Ryan, M.D.
Chairman

Continued on next page

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Committee Reports

Continued from previous page

Scholarship Committee

The Scholarship Committee met and reviewed applications from medical students for financial aid.

Ten students received aid from two separate funds. Four of these students were female.

Requests for scholarship application forms are arriving at the Society office for the 1986/87 school year.

William Coen, M.D.
Chairman

Dr. Max & Ida L. Millman Foundation

Scholarships are also available to medical students through the Dr. Max and Ida Millman Foundation. Five students received funds from this account for the 1985/86 school year. Of the five applicants approved, three were female. Donations from members and friends of the Millman Family have been received during the year.

William Coen, M.D.
Chairman

Tax Supported Medical Care

There have been no meetings of the district committee. However, there has been much activity on tax supported medical care.

There have been numerous meetings between representatives of Mass. Medical Society (headed by President Rockett) and DPW to increase physician participation in Medicaid. An agreement was worked out. MMS agreed to help recruit members, aiming for 85% participation statewide. DPW agreed to address the issues which have caused disaffection among physicians. There has been considerable progress made on both sides.

The new medical director of Medicaid, Robert J. Masters, M.D. has been very active. He is singularly aware of the needs of physicians, as well as the needs of clients/patients and of Commonwealth budgetary constraints. Under his leadership the DPW and other members of the Executive Department have persuaded the Rate Setting Commission to bring obstetrical fees into rational relation to rising overhead (including insurance premiums), even before completing their overall study of fees. At the same time payment delays have been reduced (though not eliminated). Audit techniques are undergoing change to protect the Commonwealth while abolishing unwarranted hostile assumptions by the auditors.

Dr. Masters' plans call for purchasing HMO, IPA and/or PPO policies for Medicaid clients until 80% of these clients are so covered. After 21 years of floundering since enactment of Medicaid in 1965, persons below the poverty line would at last be "mainstreamed" for medical care. The question of physician participation would become moot because the patient would present not as a DPW client, but as a policy holder of the HMO, IPA or PPO. Reimbursement, as well as audit, would be in the hands of the insurer. This would remove the Rate Setting Commission, as well as DPW from direct interaction with medical care. The immediate result in Hampden District has been that most gynecologists have expressed their willingness to participate anew in Medicaid.

Unfortunately, the Medicaid Access Coalition and some of their supporters do not understand (or do not want to understand) the parameters of access to medical care:

that some physicians render care for Medicaid clients without billing the Commonwealth,

that some physicians accept patients on referral only regardless of source of payment, and

that there is a relatively long waiting period for appointments in some specialties, regardless of source of payment.

After a long time of complete absorption with Medicaid, the MMS Committee has recently taken up the problems of Medicaid which also include payment delays, payment refusals on arbitrary basis and various harassments.

The attention of members is called to the letter of February 24, 1986 from Dr. Rockett in regard to balance billing for Medicare patients.

Walter F. Tauber, M.D.
Chairman

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Education and Library Committee

The Committee on Education and Library is completing the fifth year as a responsible body for the Springfield Academy of Medicine, having met nine times throughout the year.

The continuing Medical Education Committee, chaired by Dr. H. David Willcutts has been busy throughout the year, having sponsored twelve lectures offering CME credits.

In February, the Academy was informed that a grant from Mass. Medical Society would be available to increase library services to all members of the Hampden District Medical Society.

I wish to extend my thanks to Dr. Augusto Asinas and the HDMS Executive Committee for their continued support and concern throughout this past year.

Dr. John D. DeWeese
Chairman

Health Care Committee

The Health Care Committee is formed of the physicians who have been active in the Greater Springfield Health Care Coalition and is charged with liason with the coalition and with activities in health planning. It has been less active this year.

The Coalition continues to hold quarterly steering committee meetings. Efforts to enlist Coalition support for the upgrading of Worker's Compensation physician fees proved fruitless. A more productive alliance was developed with the Massachusetts AFL-C1O. In October, 1985, the Coalition published the "Alternate Delivery System's Buyer's Guide" which was well received by the business community. Although factual accuracy was obtained by an HDMS representative, Dr. William Baker, your chairman felt that there was insufficient emphasis on the traditional medical care delivery system. He therefore prepared a paper "Alternate to What" which was read to the steering committee.

The Coalition has formed a subcommittee on medical malpractice insurance reform under the chairmanship of Mr. Lee Deters, president of Smith and Wesson Company. The committee supported a temporary freeze on premiums and communicated this position to legislators in December, 1985.

The Coalition has expressed its concern for health planning, and has specifically noted the proposed psychiatric hospital, the IPA's proposed by Bay State and Pioneer Valley Health Care, and the MRI applications for this area. Dr. Harrison Rogers, president-elect of the AMA, addressed the January 30 meeting of the steering committee.

In other business, the Health Care Committee prepared and publicized an outline for submission of cases where needed medical care was restricted by PRO or Quality Review procedures. This form remains on file at the HDMS office, but no complaints have been received to date.

I would like to thank all those who have participated in this important community activity., Its future remains in doubt.

Respectfully submitted,
Garry Hough, III, M.D.
Chairman

Membership Committee

Our membership recruitment continues to be successful. We have 34 new members for 1985. Your membership Chairman continues to individually review every application received.

Please join us in our recruitment campaign by letting us know of any new physicians in the area. Our total membership now stands at 638 members and growing!

Franco M. Navazio, M.D.
Chairman

Medico-Legal Committee

The work of this committee has consisted largely of telephone discussions about medico-legal problems with members of the district society with occasional help from our corresponding committee in the Hampden Bar Association. We hope that in the future the medico-legal climate will be more conducive to another joint meeting between doctors and lawyers as we had several years ago.

Lester Frank, M.D.
Chairman

Medico-Religious Committee

Our Medico-Religious Committee has met every two months throughout the year. A number of physicians and clergy attended these meetings.

The major event of the committee was the September

Continued on next page

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Committee Reports

Continued from previous page

Medical Ethics Seminar, with Professor Arthur J. Dyck as the main speaker. Approximately 150 people attended this meeting.

Our committee is planning our second Medical Ethics evening for this coming September.

James G. Fitzpatrick, M.D.
Chairman

Mediation Committee

The Mediation Committee received eighteen complaints from patients or other physicians regarding the activities of member physicians. The Committee investigated and adjudicated sixteen of those successfully. One case of a complex nature was forwarded to the Mass. Medical Society Ethics Committee. One case of a serious allegation of a possibly criminal nature was forwarded to the Board of Registration in Medicine of the Commonwealth of Massachusetts.

Kenneth M. Frankel, M.D.
Chairman

Auxiliary Committee

In May Dr. Asinas, President of HDMS, asked the HDMS Auxiliary to co-sponsor a Cocktail-Dance. This was planned and held on November 1, 1985 at Yankee Pedlar Opera House with "Getting to Know You" as the theme. This was a successful rejuvenation of the White Cap Ball of the past.

The Auxiliary was asked to attend in large numbers a local public hearing on October 3rd planned by Sen. Linda Melconian, Chairman of Special Committee on Medical Malpractice, to appraise all of the malpractice situations in Mass. Many auxilians attended after excellent efforts of the Auxiliary Telephone Committee.

Many calls went to Sen. Melconian's office by auxilians before Christmas to express concern that Malpractice Insurance bills were being tabled and they felt by this deferral it would be too late to prevent a malpractice crisis. Doctors Regognition Day is being planned by the Auxiliary and they will coordinate this program with the State Auxiliary.

William W. Walthall, Jr., M.D.
Chairman

Ad Hoc Committee on Non-Dues Income

Our INTRAV trips continue to be very popular. Twenty-four people traveled with us during 1985. We have seven wonderfully varied trips planned this year, from the Alps to the Orient.

The income we received for 1985 helped us to purchase a computer for the Society's office. We thank all our members for their support.

Lewis G. Lefer, M.D.
Chairman

Public Health Committee

The Public Health Committee of the HDMS met on a monthly schedule to address several issues. The topics included:

1. Infant Mortality - with special reference to the Smith Fund.
2. Nuclear War
3. Malpractice - emphasizing the effect on access to care
4. A.I.D.S.

Infant mortality in Massachusetts and specifically in Springfield declined over the past year. However, Springfield continues to be higher than the state average which in 1984 was 8.9 per 1,000. The "Springfield Report" documented that over 64% of these deaths occurred in babies under 1000 grams with deaths reported down to 200 grams. Several high risk groups were identified; pre-term labor, minorities, women of low socio-economic resources and teens - but the problem encompasses all races, age and social strata. Modes of intervention to reduce pre-term labor would be most beneficial to reduce premature deliveries. The weight specific survival rates in the Baystate Medical Center N/CU were also found to be dramatically improved over those recorded several years ago.

The Smith Fund is one of the programs spawned by the infant mortality "crisis". It is being set up by the Springfield Department of Public Health. They have received technical assistance from the Baystate Medical Center's Departments of Obstetrics and Pediatrics, along with our Committee. The plans for the fund have not been finalized but the HDMS through this Committee has strongly recommended that it concentrate on providing ancillary services (i.e., translators, social service, W.I.C.) to private physicians in their offices for patients in need of them.

Beyond War advocate Anthony Sobey, M.D. provided a very graphic and compelling presentation concerning the results of a nuclear holocaust. The enormity of the problem is unquestionable, but making this meaningful to individuals is difficult. We are working with the School Committee in Springfield to develop a program to teach students the gravity of nuclear war without causing panic. The Committee lent its support to efforts in the Mass. Medical Society to prevent a nuclear disaster.

A.I.D.S. or acquired immune deficiency syndrome, is probably the number one Public Health issue in the media today. We reviewed and endorsed current guidelines from the Communicable Disease Center regarding A.I.D.S. We felt that there were enough responsible *ad hoc* committees regarding this disease that further action on our part was not warranted.

Finally, the committee investigated the deleterious effect of the "malpractice crisis" on access to health care. It was felt that a physician in a practice with limited financial resources would be most susceptible to the recent increase in malpractice premiums. Examples of such physicians include:

A. Physicans who by necessity or design must work abbreviated schedules, especially new mothers, and those physicians approaching retirement age.

B. Physicians whose reimbursement levels are lower than the norm, i.e., those with a practice primarily consisting of Medicaid patients.
C. Physicians in rural communities who may see fewer patients than urban based physicians.

Each of these groups represent a valuable resource for patients. The high malpractice premiums have forced physicians from each of the categories to give up practice for a short time, to join HMO's, to seek employment in other states or to retire earlier than they had planned. It was felt that this will ultimately deprive some of the most needy patients of services.

The Committee recommended that the HDMS publicize these potential problems and work vigorously through the legislature to prevent them. Unfortunately, the malpractice rates have since increased astronomically. Work in the legislature is pending and all are urged to lend their support to a sensible solution.

James F.X. Egan, M.D.
Chairman

Insurance Committee

Professional Liability

During the past year, excess malpractice coverage for occurance policies has become unavailable. One company writing excess coverage for claims-made, also withdrew. It is anticipated that all excess coverage will become unavailable. We explored the possibility of setting up a company to offer excess coverage locally or in Western Mass. using the vehicle of an "Off Shore" company. This effort was stopped due to rapidly increasing JUA premiums. It is unlikely that any alternative to the JUA will be available in Western Mass. in the foreseeable future.

Rates for 1983 and 1984 have been set by the Insurance Commissioner and will be invoiced in the near future. These rates have been appealed by the JUA. It is possible that further retro-active increases will be assessed for these years. Rates for 1985 and 1986 have not been announced. It is anticipated that there will be substantial increases for these years. Physicians can anticipate large increases in malpractice premiums for many years to come. Physicians planning to relocate or retire should plan on a significant future financial obligation...particularly those with claims-made policies.

Disability

The maximum coverage for HDMS members was increased from $600.00/week to $900.00/week last year in the Lester Burdick Plan. This increase is not limited by other disability income coverage. A return to work lump-sum payment is available as additional coverage. In this, the disabled physician receives a lump-sum payment - related to the length of disability - upon returning to work. This permits a return to practice on a part-time basis and furnishes needed cash to bridge the interval between resumption of practice and reimbursement by third party payors. This is available for both regular disability coverage and office overhead plans. Disability income coverage is available to physicians and their employees.

Health Insurance

Group health insurance is available to physicians and their employees who do not have serious health problems to the age of sixty-three. Dependents who are full-time students are covered to age twenty-five. The cost of group health insurance is age dependent.

Life Insurance

Group term life insurance is available to HDMS members and their employees. Coverage to $250,000.00 can be obtained at competitive rates. A reduction in premium is anticipated for the Spring of 1986.

All HDMS and MMS programs for disability, health and life insurance are administered by Lester Burdick, Inc., Boston, Massachusetts.

Lorne C. Smith, M.D.
Chairman

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Doctors Recognition Day

The Hampden District Medical Society Auxiliary has been planning a *Doctors Recognition Day* to be held in Hampden District on April 21, 1986. This is the Auxiliary's way of showing support for the Medical Profession by getting some simple, positive publicity before the public.

The campaign plans were presented to the Hampden District Medical Society Executive Board and approved and were presented before the Massachusetts Medical Society Auxiliary and approved. So all of the State Auxiliaries will participate in celebration of DOCTORS DAY.

The Auxiliary members will contact key majors and ask them to declare April 21, 1986 DOCTORS DAY with accompanying news coverage. We want a picture of each mayor with a well-known physician in his area, an Auxiliary member with poster, pins and a short well-written news release.

Auxiliary members will distribute DOCTORS DAY buttons to physicians in their area hospitals and offices.
We feel this is a golden opportunity to remind everyone of the important roll the Medical Profession plays in caring for and healing of the sick.

In the recent past, the Hampden District Medical Society Auxiliary has celebrated DOCTORS DAY by honoring the physicians who have completed fifty years of membership in the Hampden District Medical Society.
This year there are six Doctors who have reached this milestone and collectively they have given 350 years to Hampden District Medical Society. It is impossible to measure the tremendous impact for good these physicians have had on health care in our community through years of dedicated and caring service. Thank you and congratulations to:

Paul M. Ashton M.D.
Noah N. Feldman M.D.
Edwin J. Gillis M.D.
Harry L. Strachan M.D.
Bernard H. Tillman M.D.
Walter W. Williams M.D.

A Good Beginning
Maternal Child Health Care at Home

The Maternal Child Health Program of the Visiting Nurse Association of Springfield is a multifaceted program designed to monitor - coordinate - and educate the complete family unit. The comprehensive array of available services address the many physical, environmental and psychological considerations that are commonly demonstrated in high risk pregnancies, and often seen in uncomplicated maternities.

The Maternal Child Health team is comprised of registered nurses, and a medical social worker, equipped with special skills and expertise to assess and monitor the physical and emotional status of the mother during the pre and post partal period, to attend to the acute concerns of the new born, and even to remain as a resource during early childhood.

Current information suggests that the program has been instrumental in preventing many unnecessary admissions to acute care settings. The team frequently facilitates the referral process to other community agencies (i.e. The Women, Infant and Children Program - WIC) and is present to insure that needs of the family unit are met. The Maternal Child Health staff works cooperatively with the physician and other members of the health care team ultimately, to maintain the patient and her family at an optimum level of functioning.

During the home visit, the visiting nurse assesses the mother's physical condition and evaluates all physiological systems. Education is of course crucial. The nurse reviews with the patient and significant others, the information received from the doctor and/or clinical staff. As an example, antepartum patients would be provided with pertinent details regarding prenatal physical changes, nutritional requirements, and preparation for labor and delivery. The complementary piece that the program provides to existing medical care has been proven as invaluable.

As the expected date of confinement approaches, the visiting nurse focuses her visit to prepare for the new infant. The team re-evaluates the mother's resources and support systems, and assesses her level of understanding of general infant care.

The post natal visists concentrate on the mother's general postpartal course, and the needs of the newborn. The importance of rest, proper diet, and birth control are some of the topics that may be discussed. In conjunction with addressing maternal concerns, a thorough assessment of the infant's growth and development patterns is completed.

Ongoing supervision of mother and child continues until the family unit has stabilized. The Visiting Nurse Association of Springfield is continually seeking ways to expand and maximize the program's value to the population it serves, and at the present time, feels strongly that the Maternal Child Health Program is an invaluable, responsive, and flexible part of the services it offers to the community.

Diane Gonyea, RN
Program Development and Community Education Supervisor

American Medical Association Leadership Conference

Friday, February 21, 1986

In this article Dr. Slachta presents Secretary of Health and Human Services Dr. Otis R. Bowen's speech and then gives his own views.

Thank you Dr. Sammons, Members of the Board of Trustees, Ladies and Gentlemen of the American Medical Association. Thank you for your kind invitation to share a few minutes with you. This opportunity is special in a number of ways. Its just been over two months since President Reagan appointed me as the first physician to serve as Secretary of Health and Human Services.

My transition has not been easy, a country doctor moving from a tranquil academia position in Indiana to the bustling city of Washington. But the toughest challenge has been one of Washington's own special language--particulary when I had gotten so used to medical terms. To give you a few examples: A *bleeding heart* used to require immediate surgery to save a life. In Washington it just requires some space on the Washington Post editorial page.

I thought an *ice pack* was used to bring down swelling for contusions. In Washington, it's an organization that gives money to elect congressmen from Alaska.

I thought *"Dead on Arrival"* was the unfortunate consequence of stepping in front of a fast-moving freight train. Here it's applied to the President's budget and means "Let's raise your taxes".

This is the most puzzling--I'd always thought a *staff infection* was a wound that you treated with an antibotic. Here a staff infection is when a democrat sneaks on to your payroll.

For these reasons, I think we need more doctors in Washington--Lord knows we have enough lawyers. Think of it--less spending, less bureaucracy, less regulation....all largely due to no government on Wednesdays.

It seems appropriate that my first address is before my

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fellow physicians. We share more than just a profession. We share a concern about our family. And second, because we are also concerned about our communities, states and nations, we have become involved with, lets say, the politics of health care. Each of my three hats, family man, physician and now Secretary of Health and Human Services have unique demands and responsibilities. I am sure that is also why you became heavily involved with the AMA's activities. We all seek to contribute to a better and healthier nation.

Before I detail many of this administration's new proposals, its important to remember why we find ourselves at this important turning point in health care. The federal government's major role in health care began in 1965 with the passage of Medicare and Medicaid. They were passed with the best intentions, but quickly we learned that these programs would be bigger than anyone had believed possible. By 1970, we were spending what was projected to be spent twenty years hence by 1990. From 1966, when these programs cost about 3 billion dollars, they grew to over 60 billion by the time Ronald Reagan was elected. They grew at 20% a year rate, doubling size every 3½ years. They grew from 6% of the gross national product in 1965 to almost 11% in the mid-1980's. They, along with social security, were the reasons that federal domestic spending went from a quarter of the budget in 1960 to almost half in 1980, while defense went from half to a quarter in the same time period. They also explain why HHS has the third largest budget in the world surpassed only by the Soviet Union and the United States.

Other administrations recognized that something had to be done to control costs. Let me mention some of their most familiar methods; wage and price controls, H.S.A.s, C.O.N., P.S.R.O., voluntary and mandatory caps on hospital costs. All of these efforts shared two things; First, they were centralized and regulatory approaches to controlling costs, second, regardless of whatever saluatory effects they had on health care, they *empirically* failed to control costs. Costs continued to increase at 20% per year.

When Ronald Reagan was elected, his administration was determined to do something different. It is his intention and my aim to reduce health care costs, retain quality and accessibility and still maintain equity for the providers. As managers of a public policy, we must seek to balance three different elements: 1) Society's needs 2) Quality of care and 3) Cost Containment. The challenge is to find the *mechanism* that best balances these three elements. Regulation failed because it did not contain costs. That's why we propose *competition*. It is a better mechanism to balance need, quality and cost.

Our competition strategy entails three separate initiatives. The first is to emphasize greater consumer choice and participation. We propose voluntary vouchers, greater cost sharing in Medicare, co-payments in medicaid, more consumer information and greater co-ordination of benefits with private insurance.

The second initiative is to encourage the development of alternative systems for delivering health care. When Medicare was passed, it created Part A and Part B for hospitals and physicians, similar to Blue Cross and Blue Shield. Two-thirds of all Medicare dollars go to hospitals, one-quarter to physicians, but only 3% to home health and 1% to skilled nursing facilities. We encouraged ambulatory surgical centers, passed a hospice benefit and furthered prevention programs. In Medicaid, almost 40% of expenditures go to nursing homes. We enacted a home and community based waiver program, now operating in 46 states to help ease the situation.

The third initiative is to reform the way we paid for health care. We didn't wish to abolish fee for service, rather, we wished to develop a pluralistic and competitive health system. The most publicized reform of course is prospective payment. In the future, we may see the creation of the new Medicare HMO benefit of equal or greater importance.

So far what are the results? Although we aren't finished with reform, competition is working. Even though Medicare hospital payments increased 6% in the first year of prospective payment — that's the lowest increase in the program's history. Length of stay is down. Employment and number of beds have decreased for the first time since A.H.A. has kept records. Alternative delivery systems are proliferating. All this while hospitals have been having some of the most profitable years ever. The trust funds, for Medicare and Social Security, are now solvent. No longer are they threatened with imminent bankruptcy.

Does this mean all the problems are solved? Of course not. It merely means that some problems have been solved and the jargon has changed. Let me list a few of the items you probably have heard about:

Disproportionate share, indigent care, charity care, dumping, cost-shifting, DRG creep, early discharge sicker and quicker, capital payments, graduate medical education, freezing hospital and physician payments and rural hospital and physician payments.

This by no means exhausts the problems. Besides health care, I must also be aware of all the problems in social security, AFDC, human development services, food and drug, public health and the National Institutes of Health!
Well so much for golf on Wednesdays.

My experience as a doctor has served me well — sometimes I think that there is nothing here in Washington or at HHS that a good swig of castor oil and a few leeches couldn't cure.

Well, all of us agree that more reform is necessary. But more important to remember that the major demographic problem inherent in our society entitlement programs still exist. In 1965, there were 20 million elderly. By 1985 there were 30 million. By 2010 there will be 60 million. Although the numbers progress in a straight line, costs go up geometrically. We spend 50% more on an 85 year old Medicare patient that a 65 year old and we all know the fastest growing age group is over 75. The result can best be shown by a statement by Peter Peterson, the former Secretary of Commerece in the Nixon and Ford administration. He said that payments to the elderly were 13% of the budget in 1960. By 1980 it had grown to 25%. And if we are to meet the present commitments of our entitlement programs without expanding them for any new medical procedure or other reason, we will devote 67% of the entire federal budget to the elderly by 2010. This will be the most massive shift of income from young to old in the world's history. We used to invest in the young, in education, in our "infrastructure", but *present* law will shift this traditional American priority from the young to the elderly.

Is this good or bad? That's for all Americans to decide. But America *must* understand that it is a reality *today*. That's why the Medicare trust fund will be solvent until the turn of the century--but it will be 1 trillion dollars in res by 2010. We need greater reforms and we must begin now.

In our 1987 budget, we propose a number of health care

Continued on next page

Leadership Conference

Continued from previous page

reforms. Some of these proposals are: Phase-in hospital capital cost reimbursement into prospective payment; Reform direct medical education payments and eliminate the "doubling" of indirect medical education payments; increase part B premiums for individual payors to 35% of program costs by 1991; Extend Medicare as secondary payor to working people over 69; Cap Medicaid program costs to the states and block grant the administrative costs.

With regard to Physician re-imbursement, we propose some interim measures. We will reduce certain high priced procedures, such as pacemaker implants. We intend to consolidate the different "localities" upon which different payments are based. Does it make any sense that Texas has over 30 "localities" each with different physician payments? We think not. In the very near future, we have some additional good news. Unless Congress passes another extention to the physician fee freeze, prevailing fee screens will increase 3.15% on March 15th. Payments to physicians, however, will be reduced by 1% because of the requirements of Gramm-Rudman-Hollings. The prevailing fee screen will increase again on October 1st 1986. The amount will depend upon Congressional action on the Administration proposal to recalculate the medical economic index to reflect how other government indexes are calculated. The prevailing would increase .8% or 2.8% depending on Congressional action. The administration realizes that physician fee freezes are not the final answer. We appreciate your patience and cooperation during the freeze period. But even though physician fees were frozen, Part B of Medicare remained one of the fastest growing parts of the federal domestic budget. We all realize that these freezes and recalculations are an interim solution, as is the prospective payment for hospitals. Eventually, capitation in some form will be the ultimate re-imbursement methodology. Too often we concentrate too much of our energies on short-term repairs. In my role as Secretary, and your role as leaders of the physician community, we must address long-range solutions to our problems. We are trying to plan some innovative and exciting things.

As many of you know, President Reagan in his state-of-the-union address charged me with developing a catastrophic health coverage proposal by the end of the year. As Chairman of the Social Security Advisory Council and as a private citizen prior to my confirmation, a catastrophic health plan was considered. The President's charge, however, is much broader. He wishes us to study the entire question of catastrophic coverage, including the proper role for the private and public sector. Very soon we will be releasing the parameters of this study.

Another of my priorities is the problem of catastrophic long term care. Many have suggested long term care insurance as a possible solution. Another idea that I find attractive is a medical I.R.A. or I.M.A. It would work similarly to your I.R.A.s, but be must still cost-out this proposal. It has a short term effect on federal revenues that may conflict with our need to reduce federal deficits immediately.

As I mentioned, we are looking at capitation as one method of reforming physician and other provider payments. To put the provider, rather than the government at financial risk, is a principle that is attractive--and consistent with the operation of almost every other industry in America. In other words, healthcare is a marketable product. Capitation can be done geographically or by "coverage group." But many of the most basic questions remain to be answered. We are at the same place with capitation as we were with prospective payment in the late 1970's--at the study stage.

While we in government stress reimbursement reform, we sometimes lose sight of other important elements that need our attention. That's why one of my highest priorities is to do someting about the cost of medical malpractice insurance. If the government reforms reimbursement, it must take into account all the realities confronting a physician's practice. Without reform in the malpractice area reimbursement reform would not be complete. We realize that excessive malpractice costs do nothing to enhance the quality of health care. In an era of fiscal restraint, these dollars could be better spent elsewhere.

Speaking about the problem of malpractice is an excellent way to introduce the final area I want to address: Our role and responsibilities as physicians. We cannot expect Americans to endose any solution to the malpractice issue unless we address the central question of the physician's responsibility. If we ignore the "Bad Apples" in our profession, then we contribute to the malpractice problem. We then do not deserve any legislative relief. This is true in many other area as well. Americans trust and respect their physicians. With this trust comes great responsibility. It is my intent to bring the unique, compassionate, caring and scientific perspective of a physician to the Department of Health and Human Services.

Much has changed since I began practicing medicine over 40 years ago. Most of us in this room probably began in a one or two person office. Now we have huge hospital and health care chains. No longer is health care a "mom and pop" business. We are a victim of our own sucess and growth. Health care is now big business and it won't change in our lifetime. But although health care has changed, Americans still expect we who are physicians to be leaders and the consciences of our field. This places a heavy responsibility on each one of us. As physicians, we, more than anyone else, are witness to the great and most tragic changes in family life.

For example, only a generation ago the vast majority of children were born to two parent families. Now 60% of black children and one of seven white children are born out of wedlock. The consequences to our society, let alone government are monumental.

We have great strides reducing infant mortality. But we must be more aggressive promoting pre- and post-natal care. We must tell mothers about the serious hazards involved in smoking and drinking while pregnant. We must tell them of the tradgedy of fetal alcohol syndrome. We must talk about the risks and costs of teenage pregnancy. The number of children having children is unacceptable. We must hold teenage boys as well as girls responsible for their acts. Teenage pregnancy is a one-way ticket to poverty.

We must be sensitive to the needs of the elderly. The elderly are a valuable and an irreplaceable national resource. To ignore, abuse, or merely warehouse them deprives this nation's younger generation of the very values and traditions that we now see being eroded. If there is one thing that I would want

to do while Secretary, it is to help strengthen family life. Please don't misunderstand. Government programs do not solely cause the dissolution of the family, and government programs will not solely solve the problems of the family.

As physicians, America has been very good to us. Most of us have a lifestyle the majority of Americans can only dream about. We have been well rewarded. It is our obligation to return a portion of our time, talent and treasury to our communities, states and nation. But, we must remember that the most important and irreplaceable institution is the family. It is here that we can make a unique contibution. We must engender and enhance family values. We can do this by instruction and contibution. However, we can do this best by example. Americans expect their doctor to be a moral and community leader. We are the leaders in health care. If we aren't willing to lead, we are abdicating our role. And remember, nature abhors a vacuum. If we don't lead, someone else will. As citizens, we have the right to express our opinions--but to lead we must become publicly involved in our communities, states and nation. As physicians, we seek to heal the sick--but to lead we must take action against any physician that provides poor quality care. But perhaps most importantly, as husbands, wives and parents and grandparents we hear the anguished cry coming from the American family--but to lead we must teach and exemplify the strong moral values and traditions that we all cherish. America needs your help, and with God's help America's call shall be answered. Thank you.

COMMENTARY:

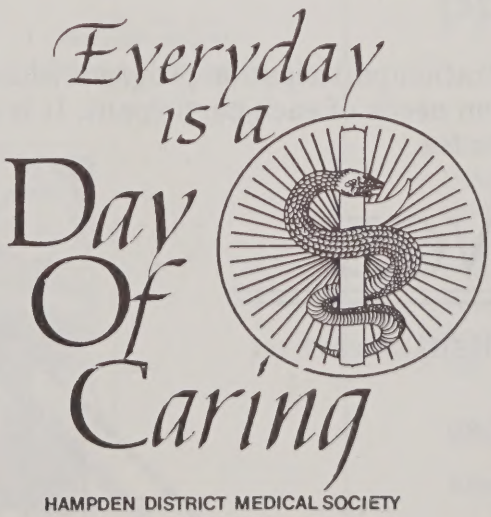
Secretary Bowen said a lot in this speech. Key is his reference to the soon to be bankrupt Medicare system, that in spite of no growth in physician reimbursement because of the freeze, increases in rate and total dollars spent continue to occur, because of the increasing utilization of services by an aging population. In 1964, the government was told, by this nations physicians, on the basis of projections of utilization, that the system would go bankrupt. Now that it is imminent, the solution is to shift the financial risk to the provider. The government once again demonstrates the courage we have learned to expect. They are not willing to address their responsibility in the inevitable need for rationing.

Secretary Bowen quotes the increase in health care expenditures as a percentage of the GNP up from 6% to 11% from 1965 to 1985. The cause, however, is attributable to the dismal economy that failed to adequately grow to support the health care needs of its citizens during those years and not the converse. He neglects to adequately address the government waste in HHS with its PRO's and CON's to fight costs. Indeed, he mentions the problems of cost shifting when he addresses indigent and charity care, dumping, and sicker and quicker egress from the hospital. Problems that are an anathema to quality care as the elderly have learned to expect. He talks of shifting the wealth of America from the youth to the elderly. A promise made by FDR and LBJ and paid for by another generations to a tune of a 1 trillion dollar deficit by 2010. Certainly, the time has come to put this high on the priority list of the national agenda.

The Medicare fee freeze may not continue but then who cares. The way it has been calculated it won't reflect the increased cost of doing business with burgeoning malpractice premiums and rents. Medicare is no longer an insurance program but now falls into the Government entitlement program. (a better paying Medicaid) Subsidized by the physicians. On the malpractice issue, I hope the Secretary does understand that he must demonstrate early initiative to continue his deficeit reduction package on our backs. The rest of his speech indicates he is somewhat of a Pollyanna. He does not understand the real pressures of providing quality care. He slips back and forth in his role of Secretary and physician with ease. Hopefully, he is not a chameleon. At least we knew where Ms. Heckler was coming from.

Gregory A. Slachta, M.D.
President-Elect HDMS

Dr. Slachta will become the HDMS President at the April 21 Annual Meeting. We have welcomed his timly articles during the past year, and we anticipate his continuing future contributions.



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Springfield Academy of Medicine Sciences Library Report

The 1985-86 year has been exceptionally busy with the installation of Medlink in June, 1985. After several training courses offered at MMS in Waltham, and many practice sessions under the steady guidance of Dr. George Pelletier, a degree of competency was reached by the Library Director in operating the electronic mail system, thereby extending faster inter-library loan services to the members.

Due to a drastic increase in the cost of journals, it was necessary to decrease by one third our journal holdings. Hopefully, with the expected grant from MMS, we will be able to re-instate those journals deleted. Through the interest from the John M. Maloney Fund, four books were added to the library shelves this fiscal year. Our appreciation is extended to Mrs. Maloney and her son, Dr. John Maloney.

Since 1986 is the year in which a portrait depicting a present day physician is to be added to the collection of portraits spanning fifty year periods from 1636 to 1936, a Physicians Portrait Fund Committee was established with Dr. James G. Fitzpatrick as Chairman. In conjunction with the fund drive, a series of articles entitled "Medicine Thru the Years" were published in the Hippocrat, giving an over-all view of the history of medicine for the past 300 years. Thus far, the fund drive has been moderately successful. Many more donations are needed to meet the goal of $3500.

Serving as president of the Western Mass. Health Information Consortium, I have presided at meetings held at Baystate Medical Center, Shriners Hospital, Franklin County Medical Center and the Hillcrest Hospital in Pittsfield. Speakers from Yale University and the V.A. Hospital in Northampton have been sponsored to further the understanding of the role of the medical librarian in today's community.

I wish to express my appreciation to Dr. John DeWeese, President, and the Board of Directors of the Academy for their unstinting support in making this a successful, productive year. I would also like to thank the HDMS Councilors for their valued support in making the Mass. Medical Society grant possible.

Margaret Stoler
Library Director

Grant Awarded by The Mass. Medical Society to S.A.M.

At the February 12th, Mass. Medical Society Council meeting held in Dedham, Ma., a motion was made and carried to award grants to the four major medical libraries in the state, one of which is the Springfield Academy of Medicine's Health Sciences Library. The actual amount of the grant will be decided by the Mass. Medical Education Committee.

The additional funds will enable the Academy library to offer greater services in the coming year to the HDMS members in the form of faster inter-library loan services, as well as access to medical data bases such as Medlars, Dialog or BRS for "searches" at no added cost to the requesting physician.

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April 14, 1986	"Malnutrition: A National Problem"	George Blackburn, M.D., Assoc. Professor of Surgery, Harvard Med. Schl., Director, Nutrition Support Service, New England Deaoness Hospital, Chief of Nutrition/Metabolism Lab, Cancer Research Institute, New England Deaconess Hospital.
May 12, 1986	"Alzheimer's Disease: Diagnosis and Treatment"	Roy Freeman, M.D., Instructor in Neurology, Harvard Medical School, Assistant Neurologist, New England Deaconess Hospital.
June 16, 1986	"Invasive Radiography"	Melvin E. Clouse, M.D., Associate Professor of Radiology, Harvard Med. School; Chairman, Dept. of Diagnostic Radiology, New England Deaconess Hospital.

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MEDICAL:	Hahnemann University 1966-70
INTERNSHIP:	Ruth-Pres. St. Lukes Med. Center, Chicago 1970-71
RESIDENCY:	Ruth-Pres. St. Lukes Med. Center, 1971-72
SPECIALTY:	VASCULAR & GENERAL SURGERY

Robert B. Steinberg, M.D.
759 Chestnut St.
Springfield, MA 01107

BORN:	December 9, 1950
PREMED:	Rice University, Houston 8/69-5/73 Case Western Reserve University, Cleveland 1973-79
MEDICAL:	Case Western Reserve University 1973-81
INTERNSHIP:	Medical Center Hospital of Vermont 7/81-6/82
RESIDENCY:	Medical Center Hospital of Vermont 1982-84
SPECIALTY:	ANESTHESIOLOGY

Robert C. Shepard, M.D.
444 Montgomery St.
Chicopee, MA 01020

BORN:	August 2, 1952
PREMED:	Harvard College Cambridge, MA 9/70-6/74
MEDICAL:	Duke Medical School 8/74-5/78
INTERNSHIP:	Cornell-NSUH 7/80-6/83
RESIDENCY:	Boston V.A.M.C. 7/81-6/83
FELLOWSHIP:	Dana-Farber Cancer Institute 7/78-6/80 Tufts NEMC 7/83-6/85
SPECIALTY:	ONCOLOGY/HEMATOLOGY

Arthur W. DeTore, M.D.

BORN:	May 30, 1953
PREMED:	Harvard University, Cambridge, MA 1971-75
MEDICAL:	Tufts University School of Medicine 1976-80
INTERNSHIP:	Christ Hospital, Oaklawn, Ill 7/80-6/81
RESIDENCY:	Baystate Medical Center 7/83-6/85
FELLOWSHIP:	Baystate Medical Center 1985-present time
SPECIALTY:	INTERNAL MEDICINE

Dinesh U. Nayak, M.D.
27 Pidgeon Drive
Springfield, MA 01119

BORN:	December 13, 1954
PREMED:	St. Aloysius College, India 1969-76
MEDICAL:	Mysore Medical College, India 1976-78
INTERNSHIP:	Mysore Medical Hospital, India 1978-79
RESIDENCY:	University of Cincinnati 1981-84
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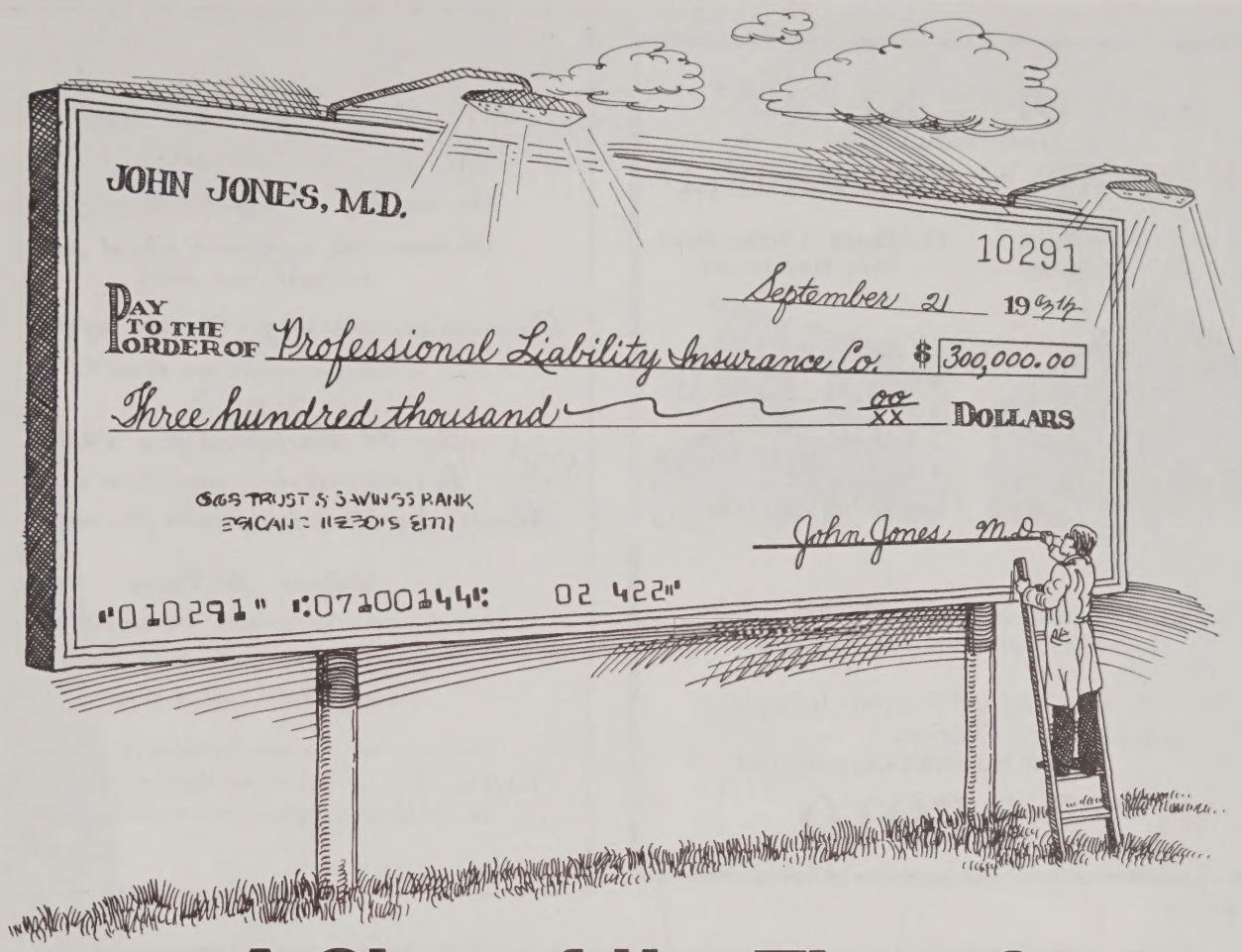
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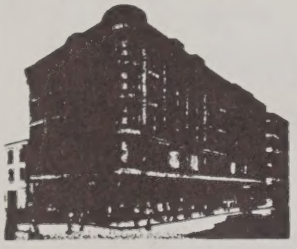

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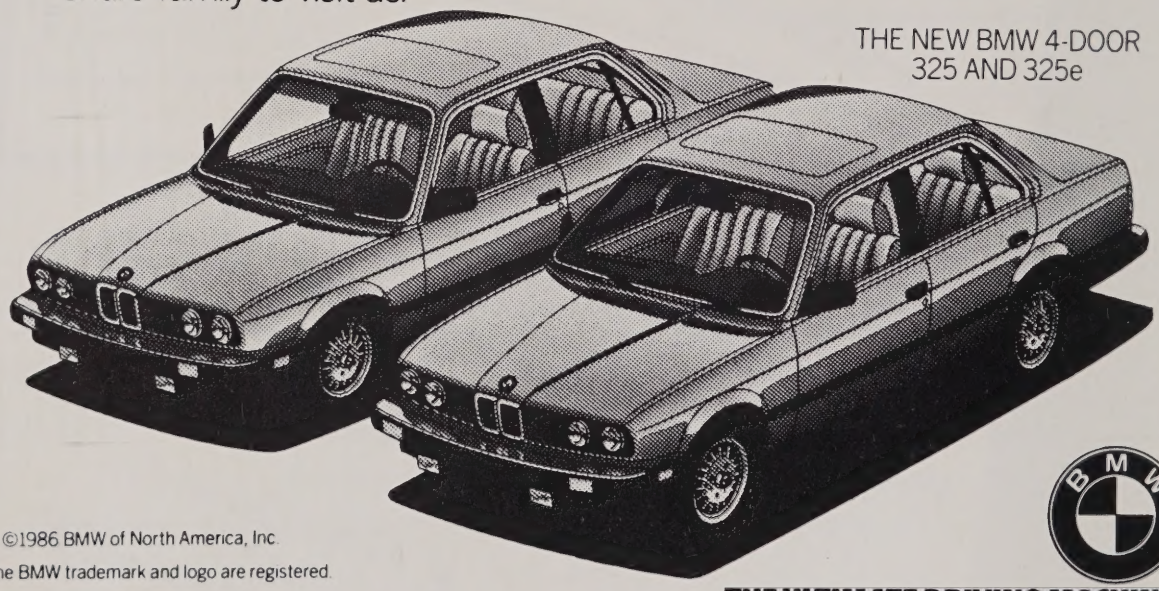
325 AND 325e



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